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Urethrocele in the Female.

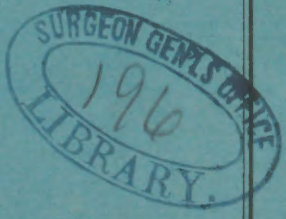
BY

ROBERT NEWMAN, M.D.,

Corresponding Member of the Gynecological Society of Boston; Surgeon to the North-Western Dispensary, New York, etc.

(WITH TWO WOODCUTS.)

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XIII., No. III., July*, 1880.



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URETHROCELE IN THE FEMALE.

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(With two woodcuts.)

URETHROCELE appears to be an innovation of the present time. Not that this ailment has not always existed, but it either has not been recognized as a disease *per se*, or it has been classified under one of its complications with which we find it often associated, as cystitis, prolapus uteri, cystocele, etc. The nomenclature signifies a difference between these diseases. Cystocele is a prolapsus of the bladder downwards, implicating the anterior wall of the vagina in its descent; but cystocele has been used by many authors synonymously with prolapsus vaginæ and vaginal hernia. For this reason I will here use cystocele as synonymous with vaginal prolapsus; on the other hand, urethrocele is a prolapsus of the urethra. First I will define the meaning of the disease under consideration. Definition: Urethrocele is an enlargement of the female urethral canal at its most depending part, causing a dilatation of the inferior wall of the urethra, making a pouch, and thereby a prolapse. A tumor is visible in the anterior wall of the vagina, and soon makes its appearance at the ostium vaginæ, rolling out the mucous lining of the vaginal wall, and carrying with it the corresponding part of the urethra, leaving the anterior wall of the urethra unchanged. The almost straight canal of the female urethra is thereby changed in its course. If a sound is introduced into the urethra at this stage of the disease, it will go almost downwards into the pouch, then upwards to the level of the meatus, and last in a straight line through about two-thirds of unchanged urethra into the bladder. This would constitute a *simple urethrocele*. If we dissect the tumor of the simple urethrocele, we will find that it consists of two principal layers: first, the membranous portion

of the vagina, and second, the corresponding membranous portion of the urethra, each portion again consisting of three layers. Therefore, the principal pathological difference between urethrocele and cystocele is as follows: Simple urethrocele consists of a part of the vagina and urethra, with a displacement of one part of the urethral canal, whereas cystocele consists of a part of the vagina alone, leaving the course of the urethral canal intact, but usually pulling down and implicating the bladder. These pathological conditions prove that urethrocele and cystocele are not synonymous, but each is a separate disease and exists by itself. Either may have complications in its progress, which will be shown later.

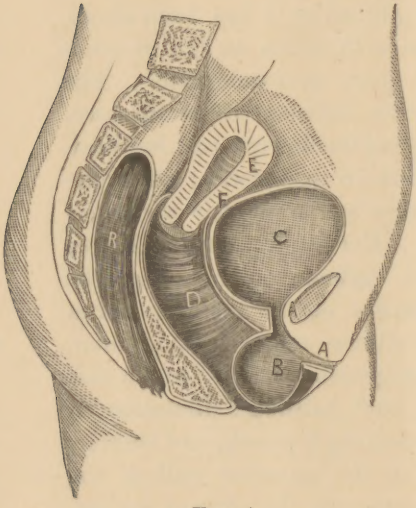

FIG. 1.

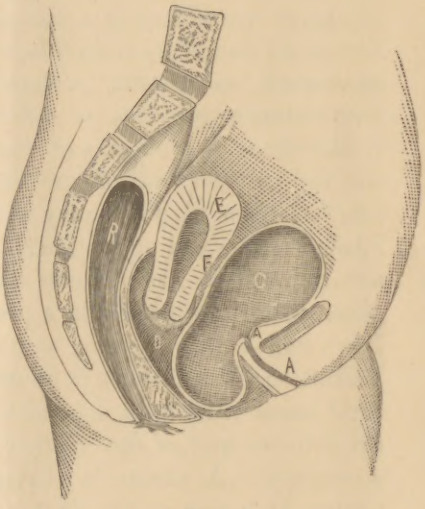

FIG. 2.

FIG. 1. Simple Urethrocele.—A, superior wall of urethra, normal; B, urethrocele, formed from inferior wall of urethra; C, bladder; D, vagina; E, uterus; F, vesico-uterine ligament.

FIG. 2. Simple Cystocele.—A, urethra not displaced; B, cystocele, a part of C, bladder, which by F, vesico-uterine ligament, pulls down the E, uterus.

Fig. 1 represents the simple urethrocele, as described here, and found particularly in case I. related in this paper.

Fig. 2 shows the uncomplicated cystocele, as I have seen it in nature, and is produced here only for comparison's sake and explanation. It is not within the scope of this paper to treat of

cystocele, for which reason I must abstain from speaking more of it; but to sustain the position taken, that in a *simple* cystocele the urethra is not displaced, I refer to Schroeder, Fig. 71, page 181, in his work on Diseases of Women.

Between these two conditions of simple urethrocele and cystocele, we may find all kinds of complications, according to the organs involved, and their degree of displacement.

Literature and History.—The first case of urethrocele which was cured by operation is mentioned by Foucher,[1] in 1857. Bozeman operated one case in 1861, which he describes in his paper on "Urethrocele, Catarrh, and Ulceration of the Bladder in Females."[2] His title shows that his cases were complicated urethrocele, not simple urethrocele. In the same paper Dr. Bozeman cites a good description of urethrocele by Sir Charles Mansfield Clark, from Vol. I. of his Diseases of Females, 1814.

One case we find recorded by Cusco in 1863.[3] One case, by Priestley,[4] was cured by compression with a Barnes rubber dilator; one case, by G. Simon,[5] was caused by varicose enlargement, which he operated by cutting the dilated veins and then cauterized with liq. ferri chloridi; one case is reported by Gillette.[6]

So far the recorded cases.

In the literature of standard works, we find a short mention of urethrocele by Veit in his Diseases of Female Sexual organs, p. 595; also in Emmet's excellent new book on Gynecology. My friend, Dr. Skene, of Brooklyn, deserves credit for devoting a large chapter to urethrocele, and describing it minutely in his new work "Diseases of Bladder and Urethra in Women," 1878. On page 306, he calls it a sacculated urethra, and describes the malady as a dilatation of the middle third of the urethra.

F. Winckel, in "Diseases of Urethra and Bladder in Females" (Pitha and Billroth, 1877), gives the subject under consideration a prominent part, and a graphic description in calling it a "Diverticulum Urethræ."

[1] Monit. des hôpit., No. 95, 1857.
[2] Transactions of the New York State Medical Society, 1871.
[3] Gaz. des hôpit., No. 124, p. 494.
[4] Brit. Med. Journ., Jan. 2d, 1869.
[5] Monatsschrift f. Gebkde., Bd. xxiii., pp. 245–248.
[6] Lancet, May 6th, 1876.

It is astonishing that other standard works on female diseases and on diseases of the urethra and bladder do not mention the disease, among which are Gross (1855), Beigel, Hewitt, Barnes, Scanzoni.

Thomas describes only a cystocele or vaginal hernia, but in his whole work on "Diseases of Women" he does not even mention a disease of the female urethra. Some authors may have neglected to speak of this disease on purpose, by having the idea that a simple urethrocele does not exist, but that it is always a complication of some other disease. Knowing that authorities disagree on this subject, I will here divide the affection under two heads.

1. *Simple Urethrocele.*—According to the above definition, a prolapse of the dependent portion of the urethra.

2. *Complicated Urethrocele.*—In which we find other displacements, as of vaginal walls, bladder, rectum and uterus, associated with the urethrocele.

Proposition I.—*Simple Urethrocele exists, and is a disease per se.*

Schroeder mentions, p. 463, the appearance of rectocele without any other displacement. If this occurs, why should not a diverticulum urethræ occur, without any other displacement? As a further proof of the proposition, the following case may be an illustration.

Case I.—*Simple Urethrocele.* Mrs. A. B., æt. 35, formerly waitress in saloons, has led an irregular life, occasional sexual excesses, is rather obese. June 22d, 1877, complains of pain in the bladder, frequent micturition with scalding of the urine, sometimes dribbling of a few drops of urine, which irritates the vulva and even excoriates the inner side of the legs. This causes her greater inconvenience than other persons, on account of her obesity.

In former years she had been under treatment several times for aggravated forms of cystitis, and, therefore, similar measures were ordered. Urine contained an excess of triple phosphates and mucus. The bladder was washed out with hot water and salt. Flaxseed tea was ordered and hot applications externally. This treatment was repeated several times. The patient was immediately relieved after each washing out of the bladder of the symptoms of cystitis, but a pain in the urethra still continued to annoy her. Besides this, the troublesome symptoms increased during the intervals of treatment.

June 30th, 1877. A small tumor in the ostium vaginæ was

noticed; the sound introduced into the meatus, passed downwards into the dilated pouch of the urethra to the base of the tumor before mentioned. The finger of the other hand, placed against the depending part of the tumor, felt the end of the sound. On following the course of the inferior dilated part of the urethra, the sound went upwards into the remaining undilated part of the urethra, which at this point was level with the meatus, and then passed easy in a straight line into the bladder. A urethrocele was thus diagnosticated. It will be noticed that the meatus, the bladder, the superior wall of the urethra, and even the part of the urethra near the bladder were unchanged; on pressure of this pouch with the finger upwards, urine was evacuated through the meatus.

Treatment.—The whole urethra was dilated, both bladder and urethra well washed out and dilated with hot water carbolized. The object of dilatation of the bladder was, to allay the vesical tenesmus, and by giving rest to the viscus, to give the urethra a chance to heal and contract. The urethra was then examined with a short endoscopic tube, and found reddened and hypertrophied, with erosions in the depending part, which being touched, bled. The spots were touched in loco per endoscope with a solution of nitrate of silver, one to three parts, which was followed immediately with an injection of warm water and salt. Rest was ordered, warm applications and injections, diet regulated, and internally an infusion of hops and folia uvæ ursi. Whenever micturition was necessary, she was advised to occupy a knee and elbow position and at the same time to elevate with one finger the diverticulum urethræ. From the very day this treatment was pursued, the patient was free from any pain, and improved rapidly.

July 5th, she reported well. The redundant portion of the pouch on the vaginal side had not disappeared then entirely, but was reduced in size, whereas the mucous membrane of the urethra had regained nearly its normal relation, so that micturition was performed through a straight urethral canal, the stream not being interrupted in its course.

It is not to be wondered at the urethra regaining its normal calibre, while the corresponding part of the vagina remains partly relaxed. The two layers of urethra and vagina are anatomically so constructed that they are loosely in contact with each other and allow a somewhat independent action. Different is the connection between uterus and bladder; here we have a more intimate adhesion at one point. The consequence is, that one organ cannot move without displacing the other. This is the reason that a prolapse of the anterior wall of the vagina is always complicated with a prolapse of the bladder, at the same time not displacing the urethra. The urethrocele always displaces the corresponding part of the anterior wall of the vagina, but the urethra sooner regains its normal size, in which the vagina follows more slowly.

The patient received the same treatment at intervals until August 1st, when she was discharged cured.

She has been under observation since, without any treatment, and never has had a sick day.

Case II.—*Simple Urethrocele in its Incipient Stage.* After this paper was written and already in press, a typical case of simple urethrocele in its incipient stage came under my observation. As rare as such a case is, it could not come at a more appropriate time to give an additional proof of the correctness of my first proposition. For this reason, I am anxious to embody a short description of it in this article.

Mrs. R. W., æt. 42 years, married 25 years ago. One year after marriage had a miscarriage at five months, after which she remained sterile. She has been a patient of mine since the year 1863, and then was treated for uterine catarrh, dysentery, and some unimportant ailment. Since the year 1866, her genito-urinary organs have remained healthy, neither has she had leucorrhea nor any displacements. Patient became a widow, and married again in 1870. Since 1871 has been under treatment off and on for dyspepsia and hysteria. Has the most aggravated globus hystericus. During the last months, from February to May, 1880, made many complaints, but none pointing to genito-urinary organs.

June, 1880, came with new complaints of hysteria, to which were added insomnia, frequent micturition with scalding of urine, pain in the urethra, and incontinence of urine. She says that the urine runs down her limbs involuntarily at any time, excoriating parts, and making the vulva swollen and sore. As she always was in the habit of complaining of so many ailments peculiar to hysteria, I had become somewhat indifferent to them. But for years she had no trouble nor complaint to make in regard to her sexual organs, and therefore these last symptoms awakened a new interest in the case.

June 8th, 1880, an examination was made. A small tumor was found in vagina, hanging down from its anterior wall and beginning below the meatus urinarius. The size of this tumor is as large as the end of the little finger, about half an inch long, and of the normal color of mucous lining. On pressure with the finger against this tumor upwards, only a few drops of urine well up through the meatus; the same pressure reduces the tumor. A sound introduced into the meatus, directed downwards, enters immediately into the pouch; the point of the sound can be felt by the finger of the other hand in the vagina, pressing the tumor upwards. On the other hand, if the sound was introduced into the meatus, with its extremity directed upwards, hugging in its advance the superior wall of the urethra, it passed easily through the urethra into the bladder. All this proves that the tumor is a urethrocele, formed by the sacculation of the inferior wall of the urethra, and that the superior wall of the urethra remains normal and is not involved or changed in this disease. This urethrocele was in its incipient stage, the diverticulum beginning near the meatus, and occupying probably not more than one-fourth

of the urethra. The pouch was small and only contained a few drops of urine, but nevertheless caused such painful symptoms and disturbance. A careful digital examination found all other organs normal, without the least displacement. The uterus was high up, rather small in size, and per speculum the mucous lining was found healthy, no sign of catarrh or any discharge. The bladder and the healthy part of the urethra were not very sensitive to the touch. As this patient has been under treatment for dyspepsia for some time past, she was under constant observation, therefore I can state positively that the symptoms indicating urethrocele appeared suddenly, and were not present previous to June, 1880.

The cause of this urethrocele was a circumscribed urethritis, probably induced by abnormal urine, chemically changed by mal-assimilation. Treatment would, therefore, be to improve her digestion, cure the dyspepsia, and thereby cause a normal urine. However, a local treatment is indispensable in order to reduce the pouch and restore the calibre of the urethra to its normal size and course.

The bladder and urethra were washed out with hot water, per catheter. Then a small endoscopic glass tube was introduced into the meatus, down to the base of the urethrocele. The mucous lining was distinctly seen inflamed, deep red, with erosions at the base, which were touched with a solution of nitrate of silver, followed immediately by a spray of salt-water. After this treatment the patient felt relieved immediately.

I am writing this on June 9th, 1880, and cannot continue to report the case, because this number of the JOURNAL is already in press. The treatment will be continued as commenced, and I am confident of the patient's speedy recovery.

Etiology.—The origin of this malady is almost always an inflammation. But there are various ways in which this is acquired, too manifold to be enumerated. Among the causes and accessories are: any traumatic accident, varicose enlargements near the meatus, as in Simon's case; stricture near the meatus, causing an obstruction to the flow of urine, too forcible dilatation or overdistention, the passage and retention of gravel and calculi, the retention of a foreign body. Other minor accessories are: indigestion; the urine chemically changed, acting as a foreign body in the urethra; venereal excesses and masturbation, by frequent frictions and consequent loosening of the attachments of the vaginal wall. Coitus into the bladder and masturbation into the urethra with a foreign body are seldom, if ever, a cause of urethrocele, according to reports of careful observers. Hyrtl, Luchapelle, Scanzoni (daily masturbation in urethra with a wax candle), Wilhelm 1864,

C. Knight 1860, Freund 1866 (coitus in urethra for ten years, had sometimes ischuria), J. Saexinger 1865; each reports one case, F. Winckel (p. 35) two cases in which the urethra was dilated so much that one finger could be introduced; in Saexinger's case even two fingers could pass, and not in a single instance did incontinence of urine ensue. Burgraeve alone reports one case of incontinence of urine, caused by coitus into the urethra.[1]

A physiological cause we may call the pressure during pregnancy and labor. Most confinements will be followed by a urethrocele, and as a rule a cure will be effected by nature's process of involution.

Symptomatology and Course.—Urethritis and cystitis with pathological changes of the urine cause the first trouble. A small residue of urine remains in the urethra, irritates, burns and itches, frequent micturition with scalding, and straining. These are the first causes of a slight dilatation of the urethra in its most dependent part, according to nature's law of gravity. No matter how small the residue is, if only a few drops or even a single drop, it will be the beginning of a dilatation and sinking of the depending part into a pouch. More fluid and solids will remain in this pouch and cause a deviation of the natural course of the urethra. There is pain in the bladder, an irritation as in cystitis, frequent desire to void urine, vesical tenesmus. The urine in bladder and urethra decomposes, causing more irritation, and more solids and fluid remain in the pouch, dilating it and pushing it more downward, pressing against the anterior vaginal wall. When this pouch has enlarged, it will in its descent carry with it the vaginal wall, which stretches, rolls outward, and appears as a small tumor in the ostium vaginæ and below the meatus urethræ. Therefore, this pouch can never be emptied; the urine, with triple phosphates in excess, ropy mucus, epithelium and pus, stands there like a cesspool without drainage. The mucous lining of the urethra thereby becomes hypertrophied, erosions and even ulcerations and hemorrhages may follow.

As the meatus has no sphincter for contraction or dilatation, the residue standing in the diverticulum will dribble away on any change of position, during walking or any movement of the patient, wetting the clothing, and excoriating the external

[1] Annales des Oculistes, vol. I., liv. XII.

parts. Hence the dribbling is almost constant, and forms one of the most aggravated troubles for the patient. In regard to situation, this dilatation begins posterior to the meatus, and occupies a little more than the anterior third of the urethra; scarcely will it extend to one-half of the urethra. From too frequent micturition and constant pain the patient has sleepless nights, the nervous system is impaired, anemia and a broken down constitution are inevitable. This picture of misery is not overdrawn, and occurs even during a simple urethrocele; on the contrary, a worse state of affairs may be present.

If we consider the anatomical relations, we will perceive how a complicated urethrocele occurs. We have seen that a urethrocele carries in its descent the corresponding part of the vaginal wall. If not checked, the whole vagina will be relaxed and pushed downwards, rolling outwards. The intimate connection of the anterior wall of the vagina with the bladder must necessarily cause a prolapse of the bladder, more tissue is displaced, rolls out, and we have a cystocele, or vaginal hernia, as some authors call it. The vagina in its normal state constitutes one of the supports of the uterus. The mucous lining of the vagina and uterus are continuous. Now, if the vaginal walls relax and roll out, the uterus loses not alone one of its supports, but is displaced and dragged down, and by degrees we will have a retroversion, a prolapsus uteri, and even procidentia. The uterus in its descent must also cause a rectocele. We may have still more complications by a ruptured perineum and cervix. Some gynecologists deny the origin of the prolapse as here described, and assert that every prolapse begins with a descent of an enlarged uterus by pressure from above, which carries the lower parts with it by invagination. That this may take place is not disputed here, but if a cystocele is caused by the uterus dragging down the other parts, it will seldom if ever be complicated with a urethrocele.

This brings me to

Proposition II.—*Complicated urethrocele is generally caused by a loss of support from below, the parts rolling out and dragging down the tissues above; but it may be caused by influences forcing the parts downwards.*

Diagnosis.—The history of the case, and the symptoms

as described above, may lead the practitioner to think of a urethrocele, but we find nearly the same symptoms in other diseases of the genito-urinary organs of females. The constant dribbling of urine from the meatus is a characteristic sign of urethrocele, but the patient's description of this may be so uncertain that we cannot make the differential diagnosis between this disease and vesico-vaginal fistula or paresis from lesions of the nervous system. The only surety for a correct diagnosis lies in a digital and ocular examination. These sure signs are: the sacculated pouch, bulging of the anterior wall of the vagina below the meatus, appearing like a tumor in the vulva rolling out of the ostium vaginæ. On handling the parts, the urine wells up out of the meatus urinarius, the pouch soon filling up again with urine, keeping up the dribbling, as described before. The introduction of the sound will show the displacement of the urethral canal; its end will be felt in the most depending portion of the pouch. Now the diagnosis is almost made without a doubt, and the only possibility of error is by excluding a neoplastic tumor—cyst or fibroid of anterior wall of vagina—which is done by examination with the sound and ocular inspection through a short endoscopic tube. And lastly, the urethrocele is reducible by pressure of the finger upwards, whereas the tumor of a neoplasm would be irreducible. To discriminate between a urethrocele and any other prolapse is easy enough, by examining the parts involved and considering their anatomical relation.

Prognosis is good, and there is no reason why a patient should not recover under proper treatment.

Treatment.—The plastic operation for the cure of urethrocele, as done by Emmet, Sims, Bozeman, and others, is generally advocated by gynecologists at the present time, no matter if the disease is simple or complicated. That such an operation is indicated in some cases, *sometimes* even is the best and shortest method, is undoubted; but there are other means which in many, if not in most cases, may be preferable, and effect a cure.

The object is to restore the dilated part of the urethra to its normal calibre and subdue all irritating causes and inflammations. Internal remedies must be given according to symptoms, as antiphlogistics to counteract inflammations, narco

ties to allay pain and tenesmus, also to procure rest and sleep; to these may be added emollients and antispasmodics. But our principal reliance consists in local treatment, and some of these may even replace the internal remedies; thus narcotics and others may be given in suppositories, subcutaneous and other injections. Hot applications externally. The bladder and urethra must be washed out as often as necessary with hot water, sometimes medicated, as required by symptoms.

This cleaning, and freeing the parts from all foreign bodies, does a great deal of good. The urethrocele proper must be examined by ocular inspection with a short endoscopic tube. Through this tube local applications are made to erosions, ulcerations, and granulations only. This is done by a small brush, with stimulating or astringent remedies, as indicated. Strong solutions must be handled carefully, so that no healthy portion of mucous lining is touched. If a larger surface of mucous membrane is reddened or hypertrophied, I have made applications with the atomizer through the same short endoscopic tubes, sometimes even with the atomizer direct.

It is my sincere conviction that most cases will get well under such treatment, if the patient is kept at rest with proper diet, careful attention, and skilful manipulations with trained assistants. Still more, I have seen a case recover eleven years ago under such treatment, after several plastic operations had utterly failed.

Lately medicated gelatine bougies have been introduced into the urethra with success.[1]

Recently a case of complicated urethrocele has come under my observation, which has been treated successfully by restoring the parts to their normal situation by means of the pessary of Dr. Wilhoft, without any other treatment or medication. Before commenting on it I will relate the case in full.

Case III.—*Complicated Urethrocele.* Prolapsus uteri, rupture of perineum, rectocele. Successful treatment with Wilhoft's pessary.

Mrs J. Walther, æt. 51 years, had first catamenia when 13 years old. Married when 22 years old and a second time 4 years later. Had 3 children, the first 1½ years after marriage, the last 22 years ago. Had 20 miscarriages, of 2, 3, 4, and 6 months, the last 8 years ago. Has menstruated regularly until her 50th year, when she ceased.

[1] F. Winckel, l. c., p. 36.

November 11th, 1879. Patient complains of incontinence of urine, which dribbles away in small quantities at any time, mostly on moving and walking, has frequent micturition, with straining and burning, has to get up five to eight times during the night to void urine, has constant deep-seated pain in the bladder, sleepless nights, and for many years a pain in the small of the back, which made her unfit to attend to her household duties and prevented her from walking any distance. She has leucorrhœa, itching of external parts, and excoriations from the dribbling of urine, which is dark, and becomes offensive soon after evacuation. Has had treatment off and on without benefit. Last month saw a celebrated gynecologist, whose assistant introduced a pessary. The instrument caused so much pain that she could not endure it longer than two days, when it was removed.

The physician advised an operation at the hospital. During April the patient saw another specialist, who also suggested an operation, which probably might relieve, but not perfectly cure her trouble.

Nov. 11th, 1879. Examination: The perineum is ruptured half-way. The ostium vaginæ is filled by two masses: the one the urethrocele, and the other a rectocele. During examination of these urine wells up out of the meatus urinarius, which latter points upwards. The pouch produced by the urethrocele is about the size of the end of the thumb, and of dark-blue color. On examing the urethra, the meatus is found very large and inflamed. The sound, with its concavity downward, passing over the sacculated urethra, produces intense pain, caused by inflammation and erosions of the pouch, which can even be seen without the endoscope. The urine in the urethral sac contains muco-pus.

When examined with the endoscope, the mucous lining was highly inflamed, hypertrophied, and the erosions covered with blood. Digital examination of the vagina shows the uterus in retroversion, resting upon the floor of the pelvis. Walls of the vagina are prolapsed.

Treatment. The retroverted uterus was replaced and held in normal position by a pessary applied by Dr. Wilhoft, which succeeded at first attempt, and the result was that the patient was free from back-ache, heaviness in the lower portion of the abdomen, and pain in the right ligamentum latum.

Nov. 12th. Has no back-ache, no bearing down, no pain of any kind, and is not aware of the presence of the pessary.

Nov. 14th. No pain, no trouble, and the uterus is well held in position by the pessary. Cervix smaller. Patient has passed water voluntarily, without any dribbling, and only four times during the twenty-four hours. Pressure against the urethrocele produces no pain, and the sac appears to be smaller.

Nov. 17th. Complains of a little pain, produced by displacement of pessary, which was caused by work.

Nov. 21st. Parts have changed; the vagina is now longer, therefore another longer pessary was adjusted, which fits very

tightly, without pinching. The pouch of the urethrocele is free from pus, and less irritable.

Nov. 22d. Patient feels perfectly well, no pain nor uneasiness, passes her urine voluntarily, one pint at a time, and was up but once last night.

Nov. 24th. Reports herself well. Pouch of urethrocele is still present, but pressure upon it causes no pain. No sign of rectocele.

Nov. 26th, walked the whole way to the office without any trouble. Feels well. Instrument fits perfectly. Handling of the parts and even pressing against the urethra can be made now without any pain or dribbling of urine. Sound passed into the urethra and downwards, which formerly was very sensitive, now gave no pain.

December 1st. Reports herself well in every respect, has no pain, retains urine well, has done her house-work, and even washing. Instrument was found in good position, fitting well, rectocele and cystocele have disappeared, pouch of urethrocele is diminished, no sensitiveness on any manipulation.

Dec. 7th. Patient considers herself well. Has done all her house-work, washing, ironing, and even sweeping, without any trouble. This she has not done in two years.

I consider this case a regular complicated urethrocele, as described above, the loss of support below by the ruptured perineum as a primary cause.

No other treatment has been used than the reduction of the parts, and retaining the same in position by the pessary.

Of course, this will not heal the ruptured perineum, but the patient will not feel any inconvenience as long as the pessary is in place.

If she had not the ruptured perineum, the pessary could soon be removed and a cure effected.

This brings us to

Proposition III. *Operations are not always necessary to cure a urethrocele;* other means may do it, particularly in simple urethrocele, and often in complicated urethrocele, without ruptured perineum.

It is conceded that an old ruptured perineum or lacerated cervix must be radically cured by the plastic operation. But even then an after-cure is needed for the retention of the parts in their normal places, which is done by the judicious application of a pessary. The conclusions arrived at in this paper may be briefly stated here as follows:

1. Simple urethrocele exists, and is a disease *per se*.

2. Complicated urethrocele is *generally* caused by a loss of support below, the parts rolling out and dragging down the tissues above; but it *may* be caused by influences forcing the parts downwards.

3. Operations are not always necessary to cure a urethrocele; other means may do it, particularly in simple urethrocele, and often in complicated urethrocele, without a ruptured perineum.

119 W. 47th St., N. Y.